IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, et al.,	
Plaintiffs,	
- against -	Civil Action No. 4:18-CV-00167-O
UNITED STATES OF AMERICA, et al.,	
Defendants,	
CALIFORNIA, et al.,	
Intervenors-Defendants.	

MOTION OF PUBLIC HEALTH SCHOLARS AND THE AMERICAN PUBLIC HEALTH ASSOCIATION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* IN OPPOSITION TO A PRELIMINARY INJUNCTION

Pursuant to Rule 7 of the Federal Rules of Civil Procedure and Rule 7.2(b) of the Local Civil Rules of the United States District Court for the Northern District of Texas, movants file this unopposed motion for leave to file a brief *amicus curiae* in opposition to the motion for a preliminary injunction. Counsel for the state plaintiffs, individual plaintiffs, federal defendants, and the state defendants have each indicated they do not oppose this motion and the filing of the attached brief. The filing of this brief is timely, as it is being filed within seven days of the defendants' briefs opposing a preliminary injunction. *See* F.R.A.P. 29(a)(6) (brief and accompanying motion must be filed "no later than 7 days after the principal brief of the party being supported is filed"). For those reasons and the reasons set forth below, leave to file the attached brief should be granted.

Movants (listed in Exhibit 3 of the Appendix to the attached brief) include public health scholars who are deans, chairs, and faculty from some of the leading schools of public health, public policy, and law in the United States. Movants also include the American Public Health Association, whose mission is to strengthen the public health profession and advocate for evidence-based public health policies. Movants are experts in the policy and science of protecting and improving the health of individuals and communities through education, and in research and scholarship related to policies that promote health, reduce preventable death and disability, and improve the quality of health care. Movants believe that public health would be adversely affected were this court to invalidate, in whole or in part, the Patient Protection and Affordable Care Act of 2010 ("ACA").

In the attached brief, movants raise relevant issues not addressed adequately in other briefs. The brief addresses two factors that the Court must consider in deciding whether to grant plaintiffs' motion for a preliminary injunction—the balance of equities and the public interest—and submits that "proper consideration of these factors alone requires denial of the requested injunctive relief." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 23 (2008). In particular, the brief demonstrates that the ACA has improved public health in the United States, including in Texas and the other plaintiff states, and that invalidating the ACA would, on balance, injure affected parties and disserve the public interest. Rather than making arguments about statutory or legislative intent, the brief principally relies on and summarizes notable empirical and scholarly studies of the ACA's positive effects on public health in the United States—which survive in substantial part the individual mandate's "zeroing out"—and the dire predictions of the harm and havoc that would ensue were the ACA enjoined in full or in substantial part.

Accordingly, the attached brief would help bring to the attention of the Court important data and analysis not fully addressed by the principal parties.

For the reasons given above, movants' unopposed motion for leave to file the attached brief *amicus curiae* should be granted.

Respectfully submitted,

/s/ Michelle L. Davis

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Certificate of Conference

Counsel for the state plaintiffs, individual plaintiffs, federal defendants, and the state defendants have each indicated they do not oppose the filing of this motion.

On June 11, 2018, Darren McCarty, counsel for the state plaintiffs, indicated that the state plaintiffs do not oppose the motion.

On June 9, 2018, Robert Henneke, counsel for the individual plaintiffs, indicated that the individual plaintiffs do not oppose the motion.

On June 11, 2018, Daniel D. Mauler, counsel for the federal defendants, indicated that the federal defendants consent to the motion.

On June 11, 2018, Neli Palma, counsel for the state defendants, indicated that the state defendants consent to the motion.

/s/ Michelle L. Davis

Certificate of Service

On June 14, 2018, I electronically submitted the foregoing document with the clerk of court for the U.S. District Court, Northern District of Texas, using the electronic case filing system of the court. I hereby certify that I have served all counsel and/or *pro se* parties of record electronically or by another manner authorized Federal Rule of Civil Procedure 5 (b)(2).

/s/ Michelle L. Davis

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BRIEF *AMICUS CURIAE* OF PUBLIC HEALTH SCHOLARS AND THE AMERICAN PUBLIC HEALTH ASSOCIATION

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

CASES

STATUTES

REGULATIONS

OTHER AUTHORITIES

INTERESTS OF THE AMICI CURIAE

Amici curiae include deans, chairs, and faculty (listed in Exhibit 3 of the Appendix) from some of the leading schools of public health, public policy, and law in the United States. Amici are experts in the policy and science of protecting and improving the health of individuals and communities through education and in research and scholarship related to policies that promote health, reduce preventable death and disability, and improve the quality of health care. Amici believe that public health would be adversely affected were this court to invalidate the Patient Protection and Affordable Care Act of 2010 ("ACA").

Amici also include the American Public Health Association ("APHA"), an organization whose mission is to champion the health of all people and all communities, strengthen the profession of public health, share the latest research and information, promote best practices, and advocate for evidence-based public health policies. APHA is the only national health organization that combines a perspective of nearly 150 years, a broad-based membership working to improve the public's health, and the ability to influence federal policy with that objective. APHA supports the increased access to health care provided by the ACA and believes that if a preliminary injunction were granted, millions would lose access to health care, health care costs would rise, health disparities would worsen and the progress made to shift the emphasis of our health care system from treatment toward prevention would be jeopardized.

ARGUMENT

"A preliminary injunction is an extraordinary remedy never awarded as of right." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008). A plaintiff must establish not only a likelihood of success on the merits and of suffering "irreparable harm" without the preliminary injunction, but also "that the balance of equities tips" in the injunction's favor and that "an injunction is in the public interest." *Id.* at 20; *see also Nichols v. Alcatel USA, Inc.*, 532 F.3d

364, 372 (5th Cir. 2008) ("A preliminary injunction is an 'extraordinary remedy' and should only be granted if the plaintiffs have *clearly* carried the burden of persuasion on all four requirements." (emphasis added) (citation omitted)).

Amici address these last two requirements—the balance of equities and the public interest—and submit that "proper consideration of these factors alone requires denial of the requested injunctive relief." *Winter*, 555 U.S. at 23; *see also id.* at 26 (noting "the importance of assessing the balance of equities and the public interest in determining whether to grant a preliminary injunction" and reversing where "the District Court addressed these considerations in only a cursory fashion"). For the reasons set forth in this brief, the ACA has substantially improved public health in the United States, including in the plaintiff states. Because an injunction would undermine these wide-ranging improvements in public health, plaintiffs seeking to enjoin the ACA have not—indeed, cannot—meet their burden.

The ACA has transformed the American health care system and improved the health of millions of Americans and their families. In the first six years of implementation (the latest data available), approximately 20 million Americans gained health insurance coverage. Expansions of Medicaid and community health centers have offered a lifeline to those least able to afford basic care. Children's health insurance enrollment has increased, and young adults are now covered as dependents. Medicare beneficiaries can now access free preventive care, and those using prescription drugs pay less. And all Americans are protected from being denied coverage based on pre-existing conditions. These strides in health insurance coverage are translating into greater availability of care—including preventive care—and improvements in health outcomes.

Without the ACA, the health of millions of Americans would be harmed. Consider the grim analyses of proposed legislation partially repealing the ACA: In 2017, the nonpartisan Congressional Budget Office ("CBO") assessed the impact of a bill partially repealing the ACA and found (among other things) that it would, in "the first new plan year following enactment of the bill" alone, increase the number of uninsured Americans by 18 million.[1] That number would grow to 27 million after the "year following the elimination of the Medicaid expansion," and then to 32 million by 2026.[2] Still more is at stake here: Unlike the injunctive relief plaintiffs seek, the bill analyzed by CBO would have staggered its partial repeal of the ACA to avoid catastrophic results.[3] Here, plaintiffs ask the Court to eliminate, as preliminary injunctive relief, a complex statute in its eighth year of implementation—a statute whose repeal through democratic means has been attempted innumerable times but has never succeeded.[4] For the reasons amici will detail below, the foreseeable public health consequences

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1 *See* Cong. Budget Office, *How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums* 1 (Jan. 2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/52371-coverageandpremiums.pdf.

2 *Id.*

3 This CBO report analyzed H.R. 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015, which would have made two primary changes.

> First, upon enactment, the bill would eliminate penalties associated with the requirements that most people obtain health insurance (also known as the individual mandate) and that large employers offer their employees health insurance that meets specified standards (also known as the employer mandate). Second, beginning roughly two years after enactment, the bill would also eliminate the ACA's expansion of Medicaid eligibility and the subsidies available to people who purchase health insurance through a marketplace established by the ACA.

Id. at 2. The bill would have not only delayed its effects on Medicaid, but it would not have rescinded the ACA in full. "Importantly, H.R. 3762 would leave in place a number of market reforms—rules established by the ACA that govern certain health insurance markets." *Id.*

4 *See, e.g.*, David Weigel, *McConnell Says Effort To Repeal Affordable Care Act Is 'Probably' Over*, Wash. Post, (Dec. 21, 2017), https://www.washingtonpost.com/news/powerpost/wp/2017/12/21/mcconnell-says-effort-to-repeal-affordable-care-act-is-probably-over/; Chris Riotta, *GOP Aims to Kill Obamacare Yet Again After Failing 70 Times*, Newsweek, (July 29, 2017), http://www.newsweek.com/gop-health-care-bill-repeal-and-replace-70-failed-attempts-643832.

of the injunction are nothing short of catastrophic.[5] The unforeseeable ones will surely be worse yet.

Under the circumstances, there can be no question that plaintiffs failed to carry their burden of proving that the balance of equities favors an injunction and that a preliminary injunction advances the public interest.

I. THE BALANCE OF EQUITIES AND THE PUBLIC INTEREST REQUIRE DENIAL OF THE REQUESTED PRELIMINARY INJUNCTION

A. Plaintiffs Have Failed To Meet Their Burden

Plaintiffs have failed to meet their "heavy burden of clearly establishing" that the balance of equities weighs in their favor and that enjoining the ACA is in the public interest. *BNSF Ry. Co. v. Panhandle N. R.R. LLC*, Civil Action No. 4:16-CV-1061-O, 2016 WL 10827703, at *2 (N.D. Tex. Dec. 30, 2016). The legislation that plaintiffs ask this Court to enjoin outright comprehensively reformed the American health care system—which encompassed 17.9% of the country's Gross Domestic Product in 2016[6]—through ten titles of interrelated statutory provisions. Yet in addressing the balance of equities and public interest, plaintiffs mention only three of the statute's provisions: the individual mandate, community-rating, and guaranteed-issue provisions. Plaintiffs concede that the ACA includes other "major" statutory provisions, but do not evaluate them for purposes of equity and the public interest—

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[5] *See, e.g.*, Allen Dobson et al., Am. Hosp. Ass'n, *Estimating the Impact of Repealing the Affordable Care Act on Hospitals* 4, Dec. 6, 2016 (concluding that ACA repeal "would threaten hospitals' ability to serve their patients and communities"); Am. Nurses Ass'n, *The High Stakes of ACA Repeal and the 2017 Senate Health Care Plan* 1, July 10, 2017 ("Removing the ACA's provisions on access to care, coverage, and cost reduction would both result in major reductions in the number of Americans with access to healthcare coverage and would result in millions more Americans not being able to afford healthcare services. The burden of these coverage losses and cost increases would fall squarely on the shoulders of some of the nation's most vulnerable – children, the elderly, and the sick.").

[6] *See* Ctrs. for Medicare & Medicaid Servs., *Historical National Health Expenditure Data*, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html (last modified Jan. 8, 2018).

much less "clearly establish" that enjoining their operation advances those values. (*See* Pls.' Br. 48–49.) And plaintiffs' casual dismissal of most of the ACA as "minor provisions" (*id.* at 48), could hardly be less apt. These provisions include, for example, the one closing the so-called Medicare "donut hole"—a reform offering seniors prescription drug benefits valued at approximately $26 billion between 2010 and 2016.[7] Plaintiffs make no mention of their intent to enjoin those benefits and countless others.

Even with respect to provisions plaintiffs do discuss, they fail to meet their burden. In addressing the equities and the public interest, plaintiffs claim that an injunction would enhance state sovereignty and reduce state expenditures. (Pls.' Br. 48, 50.) But the purported sovereign benefits—asserted by plaintiffs here without specificity—could be alleged in challenging nearly any federal legislation with which a state disagrees on policy grounds. And plaintiffs do not demonstrate that reduced expenditures—prototypically not an irreparable injury—can weigh more heavily in the balance of equities (much less the public interest) than the health, and the access to health care, of millions of Americans. *See Houston Ass'n of Alcoholic Beverage Permit Holders v. City of Houston*, 508 F. Supp. 2d 576, 587 (S.D. Tex. 2007) ("[O]n one hand, Plaintiffs suffer speculative economic harm. On the other hand, Defendant offers studies that show . . . that the health of the citizens of Houston will be detrimentally affected in ways perhaps beyond repair." (citation omitted)).

Nor do Plaintiffs explain why federal legislation on the books since 2010 should be preliminarily enjoined now, after years of implementation, upsetting the settled expectations

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[7] Press Release, Ctrs. for Medicare & Medicaid Svcs., *Nearly 12 Million People With Medicare Have Saved Over $26 Billion on Prescription Drugs Since 2010*, (Jan. 13, 2017), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-01-13.html.

of citizens, medical professionals, and governments throughout the country. Indeed, in a perverse acknowledgement of the disruption their requested relief would precipitate, plaintiffs argue that the balance of the equities favors an injunction "issued promptly," but not effective until 2019, to allow "[t]ime to prepare" for the resulting havoc. (Pls.' Br. 49.) Plaintiffs have the law backwards. "The purpose of a preliminary injunction is to preserve the status quo," not to upend it. *Hollon v. Mathis Indep. Sch. Dist.*, 491 F.2d 92, 93 (5th Cir. 1974).

Thus, whatever the court's view of plaintiffs' textual arguments in favor of ACA's invalidation (amici's view is a dim one, but we leave the matter for other briefs to address), plaintiffs' threadbare analysis of the repeal's effects must doom their request for injunctive relief. Plaintiffs' silence about the consequences of their request is conspicuous: ACA is one of the most intensely debated, litigated, and studied statutes of recent decades. Yet plaintiffs have declined to marshal before this court any material empirical evidence that repealing it would serve the balance of equities or the public interest. And, as amici show below, contrary evidence—that is, evidence of "the harm possibly resulting to other parties" and the public from the requested injunction, *Herwald v. Schweiker*, 658 F.2d 359, 363 (5th Cir. 1981)—is staggering.

II. THE ACA HAS IMPROVED PUBLIC HEALTH IN THE UNITED STATES, INCLUDING IN THE PLAINTIFF STATES, AND ENJOINING IT WOULD, ON BALANCE, INJURE AFFECTED PARTIES AND DISSERVE THE PUBLIC INTEREST

The ACA comprehensively reformed health insurance coverage and access to care, bolstered the quality and affordability of care, and strengthened the public and preventive health systems. A large body of evidence, described below, demonstrates the broad and important public health benefits of the ACA. These benefits have been shared across the

country, including in the plaintiff states, and terminating the ACA would cause harms equally widespread.

The evidence of the injunction's potential harms speaks for itself:

- **Millions of Americans could lose health insurance**. Nationwide, nearly 20 million more Americans gained insurance between 2010, when the ACA began, and 2016, the latest year for which U.S. Census data are available. Of those nearly 20 million newly insured, almost 6.8 million live in one of the plaintiff states.

- **Eliminating marketplaces and tax credits would restrict access to affordable care**. Nationwide, approximately 11.8 million Americans selected a plan from a Health Insurance Marketplace, and roughly 9.8 million received Advanced Premium Tax Credits to make their plans affordable. Of those that selected a plan from a Health Insurance Marketplace, 5.5 million live in one of the plaintiff states. Of those that received Advanced Premium Tax Credits, 4.8 million live in one of the plaintiff states.

- **Medicaid eligibility would significantly contract**. Nationwide, 32 states expanded Medicaid and, between 2013 and March 2018, approximately 17.4 million more Americans received care through that program. During the same time period, although only six of the plaintiff states expanded Medicaid, over 3.5 million more Americans within the plaintiff states enrolled in the program.

- **Pre-existing conditions could bar individuals from coverage**. Nationwide, approximately 130 million Americans are protected by the ACA's insurance reforms for individuals with pre-existing conditions. Of those 130 million, nearly 50 million live in one of the plaintiff states.

- **Young adults could lose their coverage**. Nationwide, approximately 2.3 million young adults had gained coverage because of the ACA as of 2013. Approximately 800,000 of those young adults were in one of the plaintiff states.

- **Medicare enrollees would have to pay for preventive care and pay more for prescription drugs**. Nationwide, 40 million Medicare beneficiaries had access to free preventive services, and 4.9 million paid less for their prescription medications after the ACA eliminated the so-called "donut hole" in pre-existing Medicare coverage. Of those American seniors with access to free preventive services, over 15 million live in one of the plaintiff states. Of the seniors paying less for their medications, over 1.8 million live in one of the plaintiff states.

- **Community health centers could contract, removing care from those most in need**. Nationwide, between 2010 and 2016, the number of Americans receiving care at a community health center increased by roughly 6.3 million, thanks to the ACA's provisions. Nearly 2 million of those patients live in one of the plaintiff states.

- **Funding on critical public health needs could dry up**. Nationwide, between fiscal years 2012 and 2017, grants from the ACA's Prevention and Public Health Fund totaled over $3 billion. Of that sum, over $1 billion in grants went to the plaintiff states.

This evidence is graphically summarized by state (and sources of the information are set forth) in Exhibit 1 (health insurance coverage) and Exhibit 2 (other public health services) to this brief.

In the remainder of this section, we discuss several of the key components of the ACA, and how they have improved the quality of health care and of public health across the country. We also evaluate the considerable harms to patients and the public interest that would result from an injunction. Finally, by way of example, we discuss the impact of the ACA on the State of Texas.

A. The ACA Significantly Increased Health Insurance Coverage and Enjoining Its Key Components Could Cause Millions of Americans to Lose Their Health Coverage

The number of uninsured Americans has fallen by nearly half since the passage of the ACA.[8] In 2010, 15.5% of Americans were uninsured; by 2016, that figure had fallen to 8.6%.[9] Viewed another way, 19.9 million Americans gained health coverage in that period.[10] Census data show these gains have been widespread—across every state, across adults and children, for males and females, and for all racial and ethnic groups.[11] This increase in health

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[8] There were 47,208,000 uninsured Americans in 2010; by 2016, that number had dropped to 27,304,000. *See* U.S. Census Bureau, *Health Insurance Historical Tables - HIC Series* (last revised Aug. 17, 2017), https://www.census.gov/data/tables/time-series/demo/health-insurance/historical-series/hic.html.

[9] *See id.*

[10] *See id.* (47,208,000 minus 27,304,000 equals 19,904,000); *see also* Robin A. Cohen et al., *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2016* , Nat'l Ctr. for Health Statistics 1 (May 2017) , https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201705.pdf ("In 2016, 28.6 million (9.0%) persons of all ages were uninsured at the time of interview—20.0 million fewer persons than in 2010 . . . .").

[11] *See* Bowen Garrett & Anuj Gangopadhyaya, *Who Gained Health Insurance Coverage Under the ACA, and Where Do They Live?*, Urban Inst. 5, 8–9 (Dec. 2016), https://www.urban.org/sites/default/files/publication/86761/2001041-who-gained-health-insurance-coverage-under-the-aca-and-where-do-they-live.pdf.

insurance coverage can be traced to various key components of the ACA, including (1) the development of Health Insurance Marketplaces and issuance of premium tax credits; (2) the expansion of Medicaid eligibility in the majority of states; (3) insurance reforms related to pre-existing conditions and to dependent coverage; and (4) streamlined enrollment procedures. The individual mandate likewise makes a contribution, but, as explained more fully in Part F below, its magnitude is open to debate. Indeed, "the most comprehensive analysis to date of coverage changes under the ACA related to the law's primary policy measures" concluded that the individual mandate's penalty had "a negligible impact on coverage" rates.[12]

In any event, one consequence of rescinding the ACA's key provisions is clear: millions would lose coverage. The non-partisan CBO estimates that, were the ACA's key statutory provisions eliminated, 32 million more Americans would lack health insurance by 2026.[13] A 2016 study estimated that, if the ACA were repealed, 24 million more people would be without health insurance in 2021.[14] Of those projected to lose coverage, 63.3% would have incomes below 200% of the federal poverty level, 81% would be from working families, 40% would be young adults between 18 and 34, and 66% would be individuals with, at most, a high school education.[15]

1. Millions Would Likely Lose Their Coverage Under the Marketplaces and Tax Credits

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[12] Molly Frean et al., *Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act*, 53 J. Health Econ. 72, 73 (2017).

[13] *See* Cong. Budget Office, *Cost Estimate: H.R. 1628 Obamacare Repeal Reconciliation Act of 2017* 1 (July 19, 2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52939-hr1628amendment.pdf.

[14] *See* Matthew Buettgens et al., *The Cost of ACA Repeal*, Urban Inst. 5 (June 2016), https://www.urban.org/sites/default/files/publication/81296/2000806-The-Cost-of-the-ACA-Repeal.pdf.

[15] *See id.*

In 2014, the federal and state governments began developing American Health Benefit Exchanges, *see* 42 U.S.C. § 18031-18044. Coupled with the premium tax credit—a "refundable tax credit designed to help eligible individuals and families with low or moderate income afford health insurance purchased through the[se marketplaces]"—they have helped Americans find and afford individual health insurance.[16] In 2010, 60% of people seeking individual market coverage reported it was very difficult or impossible to find affordable care.[17] By 2016, that percentage fell by roughly half.[18] As of 2018, 11.8 million Americans selected individual health insurance plans through the Health Insurance Exchanges.[19] The great majority (9.8 million of 11.8 million) had incomes between 100% and 400% of the federal poverty line and earned advance premium tax credits to defray their costs.[20] The value of these tax credits can be substantial: In 2018, factoring in the tax credits lowered average premiums in the United States from $621 per month to $153 per month.[21]

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[16] Internal Revenue Serv., *Questions and Answers on the Premium Tax Credit*, https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit (last updated Mar. 16, 2018).

[17] *See* Sara R. Collins et al., *How the Affordable Care Act Has Improved Americans' Ability to Buy Health Insurance on Their Own*, The Commonwealth Fund 5 (Feb. 2017), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/feb/1931_collins_biennial_survey_2016_ib.pdf.

[18] *See id.*

[19] Ctrs. for Medicare & Medicaid Servs., *CMS' Final Report Shows 11.8 Million Consumers Enroll in 2018 Exchange Coverage Nationwide* (Apr. 3, 2018), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-04-03.html.

[20] *See* Kaiser Family Found., *Marketplace Plan Selections with Financial Assistance*, https://www.kff.org/health-reform/state-indicator/marketplace-plan-selections-by-financial-assistance-status-2/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited May 31, 2018).

[21] *See* Kaiser Family Found., *Marketplace Average Premiums and Average Advanced Premium Tax Credit (APTC)*, https://www.kff.org/health-reform/state-indicator/marketplace-average-premiums-and-average-advanced-premium-tax-credit-aptc/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited May 31, 2018).

Were the ACA enjoined, these programs would not exist, and the health insurance of the approximately 12 million Americans utilizing these programs—approximately 10 million of whom are low- to moderate-income Americans—would be in jeopardy.

2. Millions Would Likely Lose Their Coverage Under Medicaid

The ACA extended health insurance coverage for millions of low-income Americans by expanding Medicaid eligibility. Before the ACA, most states did not cover adults without dependent children and the median income limit was about 61% of poverty for parents.[22] The ACA authorized an eligibility increase aimed at poor non-elderly adults with incomes below 138%[23] of federal poverty guidelines, and the ACA provides enhanced federal matching payments to make Medicaid more affordable for states.[24] As of early 2018, 31 states and the District of Columbia, including six of the plaintiff states, had expanded eligibility.[25] As of Fiscal Year 2016, 76 million people were enrolled in Medicaid, of whom nearly 12 million were adults newly eligible under the ACA expansions.[26]

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[22] Martha Heberlein et al., *Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012–2013*, Kaiser Family Found. 11 (Jan. 23, 2013), https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8401.pdf.

[23] HealthCare.gov, *Medicaid Expansion & What It Means For You*, https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/ (last visited May 31, 2018).

[24] Laura Snyder & Robin Rudowitz, *Medicaid Financing: How Does it Work and What are the Implications?*, Kaiser Family Found. (May 20, 2015), https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/. Pursuant to *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012), the federal government cannot require states to expand Medicaid eligibility. *Id.* at 671–91.

[25] Kaiser Family Found., *Where Are States Today? Medicaid and CHIP Eligibility Levels for Children, Pregnant Women, and Adults* (Mar. 28, 2018), https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/. In addition, in Maine, a 2016 ballot measure was passed requiring the state to expand Medicaid. *See* Matthew Bloch & Jasmin Lee, *Election Results: Maine Medicaid Expansion*, N.Y. Times (Dec. 20, 2017), https://www.nytimes.com/elections/results/maine-ballot-measure-medicaid-expansion.

[26] Kaiser Family Found., *Medicaid Expansion Enrollment*, https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited June 8, 2018).

Were the ACA enjoined, these approximately 12 million low-income adults would likely lose Medicaid and become uninsured. Furthermore, striking down the ACA would deprive states of the enhanced federal funding that supported their Medicaid expansion efforts. Between 2014 and 2015, the states that expanded Medicaid spent $84 billion on adults made newly eligible by the ACA.[27] Of that $84 billion, $79 billion was paid for with federal funds.[28] Enjoining the ACA would remove this critical source of federal funding.[29]

3. Insurance Companies Could Once Again Discriminate on the Basis of Pre-Existing Conditions

Before the ACA, Americans with serious health problems, including cancer or HIV, were often denied individual insurance coverage or were charged far more for their premiums.[30] Pre-existing condition exclusions were common for both individual and group health insurance.[31] The ACA guaranteed access to health insurance coverage and equitable pricing to protect up to 133 million Americans with pre-existing health conditions, including nearly 50 million in the plaintiff states.[32] In addition, now that individuals with serious diseases

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[27] Robin Rudowitz et al., Kaiser Commission on Medicaid and the Uninsured, *What Coverage and Financing is at Risk Under a Repeal of the ACA Medicaid Expansion?* (Dec. 2016), https://www.kff.org/medicaid/issue-brief/what-coverage-and-financing-at-risk-under-repeal-of-aca-medicaid-expansion/.

[28] *See id.*

[29] *See also* Olena Mazurenko et al., *The Effects of Medicaid Expansion Under the ACA: A Systematic Review*, 37 Health Aff. 944, 948 (Jun. 2018) (finding "evidence that the Medicaid expansion following the ACA was associated with increases in access, quality, and Medicaid spending").

[30] Sarah Lueck, *Eliminating Federal Protections for People With Health Conditions Would Mean Return to Dysfunctional Pre-ACA Individual Market*, Ctr. on Budget & Policy Priorities (May 3, 2017), https://www.cbpp.org/research/health/eliminating-federal-protections-for-people-with-health-conditions-would-mean-return.

[31] Ctrs. for Medicare & Medicaid Servs., *At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform*, https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/preexisting.html (last visited June 8, 2018).

[32] Office of the Assistant Sec'y for Planning and Evaluation, *Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act* (Jan. 5, 2017), https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf; *see also* Exhibit 2 (App'x 4).

like cancer can get health insurance, the ACA's elimination of lifetime limits on health insurance claims helps them avoid bankruptcy; these protections covered 105 million Americans.[33] Enjoining the ACA would likely make health insurance inaccessible for the 1.5 million individuals with pre-existing conditions whose incomes are 350% or more above the federal poverty line—because their coverage could have been automatically denied prior to the ACA.[34]

In addition, the ACA required that young adults under 26 years old be eligible for dependent coverage under private family insurance policies. Between 2010 (when this requirement became effective) and 2013, an additional 2.3 million young adults gained health insurance coverage.[35] Enjoining the ACA would jeopardize coverage for these young men and women working to launch their careers.

4. Administrative Efficiency Gains Would Be Undermined

Streamlined and simplified enrollment procedures owing to the ACA, as well as greater public awareness of health insurance coverage options, have also facilitated coverage—particularly for those who were already eligible for, but not enrolled in, federal health care programs. This so-called "welcome mat" effect has been substantial.[36] Nearly one million children gained coverage in the first year of implementation of the major coverage provisions of

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[33] Thomas D. Musco & Benjamin D. Sommers, *Under The Affordable Care Act, 105 Million Americans No Longer Face Lifetime Limits On Health Benefits*, Office of the Assistant Sec'y for Planning and Evaluation (Mar. 5, 2012), https://aspe.hhs.gov/sites/default/files/pdf/76401/ib.pdf.

[34] Kaiser Family Foundation, *An Estimated 1.5 Million People with Pre-Existing Conditions Could Face Higher Premiums Under Cruz Amendment* (July 11, 2017), https://www.kff.org/health-reform/press-release/an-estimated-1-5-million-people-with-pre-existing-conditions-could-face-higher-premiums-under-cruz-amendment/.

[35] Namrata Uberoi et al., *Health Insurance Coverage and the Affordable Care Act, 2010 – 2016*, Office of the Assistant Sec'y for Planning and Evaluation 5(Mar. 3, 2016), https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf.

[36] Adam Searing, *Medicaid's 'Welcome Mat' Effect Means Medicaid Expansion Helps Children Get Health Coverage*, Georgetown Univ. Health Policy Inst.(Sept. 15, 2017), https://ccf.georgetown.edu/2017/09/15/medicaids-welcome-mat-effect-means-medicaid-expansion-helps-children-get-health-coverage/.

the ACA.[37] Between 2013 (before the Medicaid expansions) and March 2018, Medicaid and Children's Health Insurance Program ("CHIP") enrollment grew by 29% and caseloads rose in all states but two (that is, even in states that did not expand Medicaid eligibility).[38]

These advancements in administrative efficiency—practical improvements that translate, among other things, into poor children having health insurance—would be lost if the ACA were suddenly halted in its tracks. And confusion resulting from a sudden change in procedures could result in even greater setbacks.

B. The ACA Improved Access to and Use of Primary and Preventive Care

1. Access to care. As common sense would suggest, ACA's advances in health insurance coverage have coincided with better access to, and use of, medical care, including preventive care. Importantly, the ACA has also contributed to declining racial and ethnic disparities in access to care.[39] The injunction plaintiffs seek would likely reverse these gains.

Statistics from the federal government's National Health Interview Survey are illustrative:

- From 2001 to 2010, the percentage of Americans who have a usual place to get medical care (*e.g.*, a regular doctor or clinic) was eroding—falling from 88% in 2001 to 85.4% in 2010. Since the ACA, however, the percentage has again risen, reaching 88.5% in 2017.[40]

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[37] Genevieve M. Kenney et al., *Children's Coverage Climb Continues: Uninsurance and Medicaid/CHIP Eligibility and Participation Under the ACA*, Urban Inst. 3 (May 2016), https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf429061.

[38] Kaiser Family Found., *Total Monthly Medicaid and CHIP Enrollment*, https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited June 8, 2018).

[39] Jie Chen et al., *Racial and ethnic disparities in health care access and utilization under the Affordable Care Act*, 54 Medical Care, no. 2, Feb. 2016, at 140–46.

[40] National Ctr. for Health Statistics, *Early Release of Selected Estimates Based on Data from the National Health Interview Survey, January–September 2017*, at 16 (Mar. 2018), https://www.cdc.gov/nchs/data/nhis/earlyrelease/EarlyRelease201803.pdf

- From 2000 to 2010, the percentage of Americans who reported being unable to get needed medical care due to cost was rising. Between 2010 and 2017, however, that percentage fell by about one third.[41]

A large body of research focuses on how Medicaid expansions under the ACA have been critical to improving access to and use of primary and preventive care, chronic care services, surgery, and mental health care.[42] For example:

- One study showed that poor adults living in two states that had expanded Medicaid were 12% more likely to have a personal physician, and indicated that there was an 18% drop in cost-related barriers for such adults, as compared to similarly situated adults living in non-expansion states.[43]

- Another study found that Medicaid expansion increased the ability of Americans with common but serious problems, like appendicitis, to get hospital surgical care, as well as to avoid such outcomes as amputation for infected limbs.[44]

- Medicaid expansions also increased access to medications used in the treatment of substance use disorder, including opioid addiction,[45] and increased coverage for

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41 *Id.* at 21.

42 Reviews include: Benjamin D. Sommers et al., *Health Insurance Coverage and Health – What the Recent Evidence Tells Us*, 377 New Eng. J. Med. 505, 586–93, https://www.nejm.org/doi/pdf/10.1056/NEJMsb1706645 (Aug. 10, 2017); Gerald F. Kominski, Narissa J. Nonzee & Andrea Sorensen, *The Affordable Care Act's Impacts on Access to Insurance and Health Care for Low-Income Populations*, 38 Ann. Rev. of Pub. Health 489 (Mar. 2017); Larisa Antonisse et al., Kaiser Family Found., *The Effects of Medicaid Expansion under the ACA: Findings from a Literature Review* (Mar. 2018), http://files.kff.org/attachment/Issue-brief-The-Effects-of-Medicaid-Expansion-under-the-ACA-Findings-from-a-Literature-Review.

43 Benjamin D. Sommers et al., *Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance*, 176 JAMA Internal Med. 1419, 1501–09 (Oct. 2016).

44 Andrew P. Loehrer et al., *Association of the Affordable Care Act Medicaid Expansion with Access to and Quality of Care for Surgical Conditions*, 153 JAMA Surgery 197, 198 (Mar. 2018).

45 Lisa Clemans-Cope et al., *Rapid Growth in Medicaid Spending on Medications to Treat Opioid Use Disorder and Overdose*, Urban Inst. (June 29, 2017) https://www.urban.org/research/publication/rapid-growth-medicaid-spending-medications-treat-opioid-use-disorder-and-overdose; Hefei Wen et al., *Impact of Medicaid Expansion on Medicaid-Covered Utilization of Buprenorphine for Opioid Use Disorder Treatment*, 55 Med. Care 336, 336–41 (Apr. 2017).

opioid-related hospitalizations,[46] as well as prescriptions filled for the treatment of other illnesses.[47]

Other research has examined the role that the Health Insurance Marketplaces and premium tax credits have played. One recent study "compared previously uninsured adults with incomes that made them eligible for subsidized Marketplace coverage (138% to 400% of the federal poverty level) to those who had employer-sponsored insurance before the ACA with incomes in the same range."[48] The study found that, "[a]mong the previously uninsured group, the ACA led to a significant decline in the uninsurance rate, decreased barriers to medical care, increased the use of outpatient services and prescription drugs, and increased diagnoses of hypertension, compared to a control group with stable employer-sponsored insurance."[49]

2. Insurance quality. In addition to improving access to health care by increasing the number of Americans covered, the ACA has also done so by improving the quality of insurance policies. In particular, the ACA limited what private insurance policies can exclude and what factors can influence premiums, and offered free preventive care services to seniors on Medicare.

Before the ACA, many insurance policies failed to cover essential services. For example, 62% of individual insurance policies lacked maternity coverage, 34% did not cover substance abuse services, 18% lacked mental health coverage, and 9% did not have prescription

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[46] Matt Broaddus et al., Ctr. on Budget & Policy Priorities, *Medicaid Expansion Dramatically Increased Coverage for People with Opioid-Use Disorders, Latest Data Show* (Feb. 28, 2018).

[47] Ausmita Ghosh et al., Nat'l Bureau of Econ. Research, *The Effect of State Medicaid Expansions on Prescription Drug Use: Evidence from the Affordable Care Act*, NBER Working Paper No. 23044 (Jan. 2017), http://www.nber.org/papers/w23044.

[48] Anna L. Goldman et al., *Effects of the ACA's Health Insurance Marketplaces on the Previously Uninsured: A Quasi-Experimental Analysis*, 37 Health Aff. 519, 591–99 (Apr. 2018).

[49] *Id.*

drug coverage.[50] The ACA requires that non-grandfathered private insurance policies and Medicare offer these and other "essential health benefits." 42 U.S.C. 300gg-6(a). That requirement has helped, among others, pregnant women and newborns; one recent study found that the ACA's expansion of coverage to young women increased access to prenatal care and reduced rates of preterm birth.[51]

To take another example, enjoining the ACA would place millions of Americans who gained coverage for mental health and substance use disorder treatment at risk of losing access to these critical services.[52] These losses would deal a severe blow to our country's battle against the opioid epidemic, as there is no guarantee insurance plans will continue to cover crucial treatment for opioid use disorder.[53]

To increase the availability and use of preventive care services—such as immunizations, cancer screenings, and contraception—the ACA also requires coverage without cost-sharing of preventive health services with demonstrated effectiveness. For example, the number of women able to use contraception, including more effective long-acting reversible contraceptive methods, has increased.[54]

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50 Office of the Assistant Sec'y for Planning and Evaluation, *Essential Health Benefits: Individual Market Coverage* (Dec. 16, 2011), https://aspe.hhs.gov/system/files/pdf/76356/ib.pdf.

51 Jamie R. Daw & Benjamin D. Sommers, *Association of the Affordable Care Act Dependent Coverage Provision With Prenatal Care Use and Birth Outcomes*, 319 JAMA 579, 579 (Feb. 13, 2018), https://jamanetwork.com/journals/jama/article-abstract/2672632.

52 Jane B. Wishner, *How Repealing and Replacing the ACA Could Reduce Access to Mental Health and Substance Use Disorder Treatment and Parity Protections*, Urban Inst. 1 (June 2017), https://www.urban.org/sites/default/files/publication/90791/2001305-how-repealing-and-replacing-the-aca-could-reduce-access-to-mental-health-and-substance-use-disorder-treatment-and-parity-protections.pdf.

53 *Id.*

54 Caroline S. Carlin et al., *Affordable Care Act's Mandate Eliminating Contraceptive Cost Sharing Influenced Choices of Women with Employer Coverage*, 35 Health Aff. 1608, 1613 (2016).

3. Community health centers. Beyond insurance, the ACA created a mandatory fund to increase federal funding for community health centers.[55] Community health centers are safety net clinics that serve millions of uninsured as well as Medicaid patients in areas that are medically underserved, ranging from inner cities to frontier areas in all states.[56] ACA's increased funding, in turn, helped increase the capacity of community health centers.[57] The number of patients receiving care at such facilities rose from 19.5 million in 2010 to 25.9 million in 2016.[58]

C. Rescinding the ACA Would Harm Seniors and Could Disrupt Medicare

The ACA has conferred tangible health care benefits on the elderly. In a significant reform, the ACA eliminated the so-called "donut hole," the gap in Medicare coverage between initial prescription drug assistance and coverage for very high expenditures.[59] In 2016, as many as 5 million Medicare beneficiaries received this benefit, with an average value of $1,149.[60] Between 2010 and 2016, the improved prescription drug benefits were valued at $26 billion.[61]

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55 Cong. Research Serv., The Community Health Center Fund: In Brief (Jan. 13, 2017), https://www.everycrsreport.com/reports/R43911.html.

56 *See* Health Res. & Servs. Admin., MUA Find, https://datawarehouse.hrsa.gov/tools/analyzers/muafind.aspx (last visited May 31, 2018); *see also* Peter Shin et al., *Changes in Health Center Patients Served, 2010-2016*, Milken Inst. Sch. of Pub. Health & RCHN Cmty. Health Found., (Jun. 2018), https://publichealth.gwu.edu/sites/default/files/downloads/HPM/GGHealthCenterDataInsights_June%202018.pdf.

57 Xinxin Han et al., *Medicaid Expansions and Increases in Grant Funding Increased the Capacity of Community Health Centers*, 36 Health Aff. 49 (2017).

58 Sara Rosenbaum et al., Kaiser Family Found., *Community Health Centers: Growing Importance in a Changing Health System* (Mar. 2018), http://files.kff.org/attachment/Issue-Brief-Community-Health-Centers-Growing-Importance-in-a-Changing-Health-Care-System.

59 Medicare.gov, *Closing the Coverage Gap – Medicare Prescription Drugs Are Becoming More Affordable* (Dec. 2017), https://www.medicare.gov/Pubs/pdf/11493.pdf.

60 Ctrs. of Medicare & Medicaid Servs., *State-by-State Information on Discounts in the Medicare Part D Donut Hole through December 2016*,

(cont'd)

In addition, similar to the private-insurance preventive care reforms discussed above, seniors have also benefited from an ACA provision that authorized free preventive services—such as cancer screenings, immunizations, and an annual wellness visit—for Medicare beneficiaries. In 2016, 40.1 million Medicare beneficiaries received at least one free service, including 10.3 million who made a wellness visit.[62]

Rescinding the ACA and regulations promulgated under its authority would likely reverse these benefits. It could also likely wreak havoc on the administration of Medicare, as key regulations governing Medicare's operations would be called into question.[63]

D. The ACA Improves Health Outcomes

Preliminary evidence suggests that the ACA has improved health outcomes. While health outcomes take years to materialize and are affected by a number of confounding factors, many studies over the past decade have shown that insurance coverage generally produces "significant, multifaceted, and nuanced benefits to health."[64] The ACA's expansion of coverage has improved individuals' self-reported health status,[65] which is an indicator of

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(cont'd from previous page)
https://downloads.cms.gov/files/Part%20D%20Donut%20Hole%20Savings%20by%20State%20YTD%202016.pdf (last visited June 5, 2018).

61 Press Release, Ctrs. for Medicare & Medicaid Servs., *Nearly 12 Million People With Medicare Have Saved Over $26 Billion On Prescription Drugs Since 2010* (Jan. 13, 2017), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-01-13.html.

62 *Id.*

63 For example, the Medicare rule covering hospital costs and payments expressly relies on the ACA as one of its legal authorities. Final Rule Relating to Medicare Program, 82 Fed. Reg. 37990 (Aug. 14, 2017) (codified in scattered parts at 42 C.F.R.).

64 Benjamin D. Sommers et al., *Health Insurance Coverage and Health – What the Recent Evidence Tells Us*, 377 New Eng. J. of Med. 586, 591 (Aug. 10, 2017), https://www.nejm.org/doi/pdf/10.1056/NEJMsb1706645.

65 *See* Benjamin D. Sommers et al., *Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance*, 176 JAMA Internal Med. 1501 (Oct. 2016); Kao-Ping Chua & Benjamin D. Sommers, *Changes in Health and Medical Spending Among Young Adults Under Health Reform*, 311 JAMA 2437 (2014).

subjective well-being and is a strong predictor of mortality.[66] As a result of the ACA's dependent care coverage expansion that allowed young adults to gain insurance under their parents' policies, the mortality rate for young adults for diseases amenable to medical care decreased.[67] Furthermore, expansion of Medicaid eligibility under the ACA reduced hardships associated with paying medical bills and reduced psychological distress among low-income parents.[68]

While data on the effects of the ACA are still preliminary, studies have found that expansions of Medicaid and insurance coverage lead to positive health outcomes. In Oregon, a Medicaid expansion in 2008 based on a lottery drawing lowered depression and reduced financial strain among participants.[69] A study of Medicaid expansion in Arizona, Maine, and New York between 2000 and 2005 found that Medicaid expansion reduced mortality rates in these states.[70] And studies documenting the 2006 health care reform effort in Massachusetts, often considered a model for the ACA, have found that it reduced mortality.[71]

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66 *See, e.g.*, Karen B. DeSalvo et al., *Mortality Prediction with a Single General Self-Rated Health Question: A Meta-Analysis*, 21 J. of Gen. Internal Med. 267 (2006) (finding that individuals with poor self-related health had a higher mortality risk than those with excellent self-rated health).

67 *See* Chandler McClellan, *The Affordable Care Act's Dependent Care Coverage and Mortality*, 55 Med. Care 514 (2017).

68 *See* Stacey McMorrow et al., *Medicaid Expansion Increased Coverage, Improved Affordability, and Reduced Psychological Distress for Low-Income Parents*, 36 Health Aff. 808 (2017).

69 *See* Katherine Baicker et al., *The Oregon Experiment – Effects of Medicaid on Clinical Outcomes*, 368 New Eng. J. of Med. 1713 (2013).

70 *See* Benjamin D. Sommers et al., *Mortality and Access to Care Among Adults After State Medicaid Expansions*, 367 New Eng. J. of Med. 1025 (2012).

71 *See* Benjamin D. Sommers et al., *Changes in Mortality After Massachusetts Health Care Reform: A Quasi-Experimental Study*, 160 Anns. of Internal Med. 585 (2014).

E. The ACA Invests in Programs to Further Strengthen Public Health and Health Systems Innovations

The ACA also includes programs to bolster public health and prevention initiatives, improve the health workforce, and foster innovation in value-based and patient-centered care through research and demonstrations. The following evidence is only partly illustrative of the ACA's considerable programmatic efforts.

The Prevention and Public Health Fund provides support to a variety of public health investments.

- Between Fiscal Years 2012 to 2017, it provided roughly $3.36 billion in funding for public health services.[72]
- In 2016, it supported 12% ($890 million) of the Centers for Disease Control and Prevention's total budget, of which $625 million was allocated to state and local public health efforts such as immunization and smoking cessation.[73]
- Among other things, the fund supported CDC's *Tips from Former Smokers* campaign, which helped 500,000 people quit smoking for good in the first four years of the campaign, at an estimated cost of $2,000 for every life saved from a smoking death.[74]

The ACA also invested in developing and testing new ways to improve the value of health care and patient-centered care.

- The ACA created the Maternal, Infant, and Early Childhood Home Visiting ("MIECHV") Program, which between Fiscal Years 2010 and 2014 invested $1.5 billion in innovative programs to support new families.[75] This program has been demonstrated to reduce costs related to medical care, child welfare, special

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[72] *See* Exhibit 2 (App'x 4); *see also* Trust for America's Health, *Updated Prevention and Public Health Fund (PPHF) State Funding Data (FY10-FY17)* (last updated Mar. 27, 2018), http://healthyamericans.org/health-issues/news/updated-prevention-and-public-health-fund-pphf-state-funding-data-fy10-fy17/.

[73] *See* Albert Lang et al., *A Funding Crisis for Public Health and Safety: State-by-State Public Health Funding and Key Health Facts*, Tr. for Am.'s Health 6 (Mar. 2018).

[74] Ctrs. for Disease Control and Prevention, Tips Impact and Results, https://www.cdc.gov/tobacco/campaign/tips/about/impact/campaign-impact-results.html?s_cid=OSH_tips_D9391 (last updated May 17, 2017).

[75] *See* Ted R. Miller, *Projected Outcomes of Nurse-Family Partnership Home Visitation During 1996-2013, USA*, 16 Prevention Science 765 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4512284/.

education, and the criminal justice system—with expected savings that far outweigh the program's cost.[76]

- The ACA established the Center for Medicare and Medicaid Innovation ("CMMI"), supported with $10 billion between 2011 and 2019, and allocated another $10 billion each decade thereafter.[77] One notable effort is the Diabetes Prevention Program.[78] Testing by CMMI determined that supporting nutrition and physical activity programs for seniors could prevent diabetes, saving $2,650 for each enrollee.[79] The Diabetes Prevention Program is now a Medicare-covered service across the nation.[80]

- The Patient Centered Outcomes Research Institute, authorized under the ACA, supports research about better ways to help patients and health care providers make better health care decisions, such as research about better ways to manage chronic pain that can reduce the use of addictive opioid pain medications.[81]

- The ACA also increased funding for the National Health Service Corps, which provides incentives for health professionals to practice in areas that have an insufficient supply of doctors, dentists, or mental health providers.[82] It also supports programs to increase the supply of trained professionals qualified to provide integrated health service.[83]

Enjoining the ACA would undermine funding for these important and prudent investments in public health initiatives and research.

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[76] *See id.* ("The $3.0 billion in expected TANF, food stamp, and Medicaid spending reductions (95% CI: $2.0-$4.1 billion) far exceed the program's $1.6 billion cost.").

[77] Kaiser Family Found., *"What is CMMI?" and 11 other FAQs about the CMS Innovation Center*, (Feb. 27, 2018), https://www.kff.org/medicare/fact-sheet/what-is-cmmi-and-11-other-faqs-about-the-cms-innovation-center/.

[78] *See* Ctrs. for Medicare & Medicaid Servs., *Medicare Diabetes Prevention Program (MDPP) Expanded Model*, https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/ (last updated May 31, 2018).

[79] *See* Paul Spitalnic, Chief Actuary, Ctrs. for Medicare & Medicaid Servs., *Certification of Medicare Diabetes Prevention Program*, (Mar. 14, 2016), https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/Diabetes-Prevention-Certification-2016-03-14.pdf.

[80] *See* Ctrs. for Medicare & Medicaid Servs., *Fact Sheet: Final Policies for the Medicare Diabetes Prevention Program Expanded Model in the Calendar Year 2018 Physician Fee Schedule Final Rule*, https://innovation.cms.gov/Files/fact-sheet/mdpp-cy2018fr-fs.pdf (last visited June 9, 2018).

[81] *See* Patient Centered Outcomes Research Inst., *Highlights of PCORI-Funded Research Results*, https://www.pcori.org/research-results/explore-our-portfolio/highlights-pcori-funded-research-results (last updated Mar. 27, 2017).

[82] *See* Elayne J. Heisler, Cong. Research Serv., R44970, *The National Health Service Corps* (2017).

[83] *Id.*

F. Current ACA Benefits Will Survive the Individual Mandate's "Zeroing Out"

A comprehensive analysis of the effects of key components of the law, including the premium tax credits for the Health Insurance Marketplaces, Medicaid eligibility expansions, and the individual mandate, concluded that the level of the individual mandate penalties had little impact on the number of Americans who gained insurance coverage under the ACA.[84] This argument finds support elsewhere. A separate study, published this year, concluded that eliminating the individual mandate would only have modest "non-fatal" effects on insurance coverage, including participation in the Health Insurance Marketplace, in California.[85] Indeed, in November 2017, the CBO estimated that repeal of the individual mandate would reduce insurance coverage by 4 million people in 2019[86]; but by May 2018, the CBO had reduced its estimate of the effect by about one-third.[87] Although terminating the individual mandate may raise Marketplace premiums for those who are not eligible for tax credits,[88] the remaining components of the law (including Marketplace subsidies, Medicaid expansion, the dependent coverage provision expanding parental insurance until age 26, and numerous other features) will continue to function and improve health coverage and public health benefits. Major—indeed,

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[84] Molly Frean et al., *Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act*, 53 J. of Health Econ. 72, 86 (May 2017).

[85] John Hsu et al., *Eliminating The Individual Mandate Penalty In California: Harmful But Non-Fatal Changes In Enrollment And Premiums*, Health Affairs Blog (Mar. 1, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180223.551552/full/.

[86] Cong. Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* (Nov. 2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf.

[87] Cong. Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65; 2018 to 2028* 20 (May 2018), https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53826-healthinsurancecoverage.pdf.

[88] *See, e.g.*, Am. Acad. of Actuaries, *Issue Brief: Drivers of 2018 Health Insurance Premium Changes* (July 2017) ("A weakening or elimination of the individual mandate would be expected to increase premiums . . . ."), https://www.actuary.org/content/drivers-2018-health-insurance-premium-changes.

most—elements of the ACA will be unaffected and remain intact, and will continue to improve insurance coverage and access to care.

G. Texas Benefits from the ACA and Would Be Harmed by an Injunction

The positive effects of the ACA to citizens of plaintiff states are summarized above and in Exhibits 1 and 2. A case study of Texas illustrates both the significant benefits from implementation of the ACA and the severe injuries that could result from the ACA's enjoinment.

Although Texas lags behind other states in rates of health insurance (including among children), the ACA has helped it to make significant progress. In 2018, 1.1 million Texans purchased health insurance through the ACA exchange during the open enrollment season.[89] Between 2010 and 2015, the number of individuals without health insurance in Texas decreased by 1.78 million as a result of the ACA.[90] Given the size of its population, Texas actually has one of the highest numbers of health care exchange enrollments in the country, surpassed only by Florida and California.[91] The subgroups that experienced the largest increases in insurance coverage were 50- to 64-year-olds, Hispanics, persons reporting fair or poor health, and individuals whose highest level of educational attainment was a high school diploma.[92]

Repealing the ACA would be catastrophic for Texans. Over 4.5 million residents, or 27% of the non-elderly population, had pre-existing conditions that would have been

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89 Louise Norris, *Texas health insurance marketplace: history and news of the state's exchange*, healthinsurance.org (May 8, 2018), https://www.healthinsurance.org/texas-state-health-insurance-exchange/.

90 *Id.*

91 *Id.*

92 Stephen Pickett et al., *Gain in Insurance Coverage and Residual Uninsurance Under the Affordable Care Act: Texas, 2013-2016*, 107 Am. J. of Pub. Health 120 (2017).

declinable under pre-ACA practices.[93] Insurance companies could once again turn away those Texans. As a result of the ACA, seniors and individuals with disabilities in Texas have saved over $1.4 billion on drug costs.[94] Those costs would likely again rise as a result of an injunction. Over 360,000 more Texans were able to get quality primary care medical, dental, or mental health services at community health centers located in medically underserved areas. And between 2012 and 2016, Texas received over $143 million from the Prevention and Public Health Fund. That funding could disappear. By 2027, as one state-by-state analysis of the effect of eliminating the ACA found, roughly 2.8 million fewer Texans would have health insurance were the ACA rescinded.[95]

In short, within Texas—and nationwide—millions of Americans will risk losing access to the care they need, and millions of Americans will pay more for the care they do receive, if the ACA were rescinded. Plaintiffs have failed to develop a record demonstrating that these baleful outcomes would be outweighed by an injunction's benefit—much less showing that the injunction's catastrophic results would serve the public interest.

CONCLUSION

Because Plaintiffs fail to demonstrate that the balance of the equities tips in their favor and that an injunction would serve the public interest, Plaintiffs' motion for a preliminary injunction should be denied.

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93 Gary Claxton et al., *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA*, Kaiser Family Found. (Dec. 12, 2016), https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/.

94 Families USA, *Defending Health Care in 2017: What Is at Stake for Texas* (Dec. 2016), http://familiesusa.org/product/defending-health-care-2017-what-stake-texas.

95 Emily Gee, Ctr. For Am. Progress, *Coverage Losses by State Under the Graham-Cassidy Bill to Repeal the ACA* (Sept. 20, 2017), https://www.americanprogress.org/issues/healthcare/news/2017/09/20/439277/coverage-losses-state-graham-cassidy-bill-repeal-aca/.

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Dated: June 14, 2018

Certificate of Service

On June 14, 2018, I electronically submitted the foregoing document with the clerk of court for the U.S. District Court, Northern District of Texas, using the electronic case filing system of the court. I hereby certify that I have served all counsel and/or *pro se* parties of record electronically or by another manner authorized Federal Rule of Civil Procedure 5 (b)(2).

/s/ Michelle L. Davis

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

- x

TEXAS, et al.,

:

Plaintiffs,

:

- against - Civil Action No. 4:18-CV-00167-O

:

UNITED STATES OF AMERICA, et al.,

:

Defendants,

:

CALIFORNIA, et al.,

:

Intervenors-Defendants.

:

- x

APPENDIX
TO BRIEF *AMICUS CURIAE* OF
PUBLIC HEALTH SCHOLARS AND
THE AMERICAN PUBLIC HEALTH ASSOCIATION

Respectfully submitted,

/s/ Michelle L. Davis

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/s/ Michelle L. Davis

EXHIBIT 1

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Chart of Selected Measures of ACA Effects on Health Insurance Coverage in the Nation and Plaintiff States[1]

State	Increase in Number of Residents Insured, 2010-16 (a)	Increase in Percent of Residents Insured, 2010-16 (b)	Persons Who Selected Marketplace Plan, 2018 (c)	Persons Who Received Advanced Premium Tax Credit, 2018 (d)	State Expanded Medicaid, as of 2018 (e)	Changes in Medicaid Enrollees, 2013 - March 2018 (f)	Gains in Young Adults' Insurance Coverage, 2013 (g)
	# persons	% points	# persons	# persons	# states	# persons	# persons
United States	***19,904,000***	***6.9***	***11,750,175***	***9,770,291***	***32 States***	***17,376,908***	***2,300,000***
20 Plaintiff States	***6,785,000***	**6.7**	***5,536,632***	***4,809,571***	***6 States***	***3,550,918***	***884,000***
Alabama	252,000	5.5	170,211	152,232	No	102,987	35,000
Arizona	384,000	6.9	165,758	136,076	Yes	476,307	50,000
Arkansas	269,000	9.6	68,100	57,558	Yes	335,700	21,000
Florida	1,397,000	8.8	1,715,227	1,565,486	No	563,447	132,000
Georgia	566,000	6.8	480,912	408,933	No	277,105	74,000
Indiana	418,000	6.7	166,711	112,479	Yes	336,281	50,000
Kansas	140,000	5.2	98,238	81,500	No	18,585	22,000
Louisiana	321,000	7.5	109,855	93,726	Yes	440,800	34,000
Maine	27,000	2.1	75,809	64,633	No[2]	N/A	8,000
Mississippi	182,000	6.4	83,649	77,083	No	16,114	22,000
Missouri	242,000	4.3	243,382	202,915	No	104,918	44,000
Nebraska	47,000	2.9	88,213	80,959	No	2,053	14,000
North Dakota	13,000	2.8	22,486	18,759	Yes	24,518	7,000
South Carolina	309,000	7.5	215,983	191,458	No	124,960	35,000
South Dakota	25,000	3.7	29,652	26,912	No	3,149	6,000
Tennessee	307,000	5.4	228,646	192,384	No	275,515	47,000
Texas	1,330,000	7.1	1,126,838	962,396	No	193,854	205,000
Utah	157,000	6.5	194,118	171,368	No	5,218	25,000
West Virginia	170,000	9.3	27,409	23,542	Yes	194,869	12,000
Wisconsin	229,000	4.1	225,435	189,172	No	54,538	41,000

[1] Sources for these statistics are identified on the following page and correspond to the parenthetical letter in each column heading. For example, for the sources of statistics in the column "Increase in Number of Residents Insured, 2010-16 (a)," see the text at "(a)" on the following page.

[2] Maine adopted the Medicaid expansion through a ballot initiative in November 2017, but it had not been implemented as of May 31, 2018.

(a) Increase in Number of Residents Insured, 2010-16. These figures are based on data available at U.S. Census Bureau, *Health Insurance Historical Tables - HIC Series* (last revised Aug. 17, 2017), https://www.census.gov/data/tables/time-series/demo/health-insurance/historical-series/hic.html. In particular, these figures represent the difference between the uninsured estimates from 2016 and those from 2010, as taken from the spreadsheet, "HIC-4. Health Insurance Coverage Status and Type of Coverage – All Persons: 2008 to 2016."

(b) Increase in Percent of Residents Insured, 2010-16. As above, these figures are based on data available at U.S. Census Bureau, *Health Insurance Historical Tables - HIC Series* (last revised Aug. 17, 2017), https://www.census.gov/data/tables/time-series/demo/health-insurance/historical-series/hic.html. In particular, these figures represent the difference between the uninsured percentage estimates from 2016 and those from 2010, as taken from the spreadsheet, "HIC-4. Health Insurance Coverage Status and Type of Coverage – All Persons: 2008 to 2016."

(c) Persons Who Selected Marketplace Plan, 2018. These figures are available at Kaiser Family Foundation, *Marketplace Plan Selections with Financial Assistance*, https://www.kff.org/health-reform/state-indicator/marketplace-plan-selections-by-financial-assistance-status-2/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited June 5, 2018). In particular, see the column, "Total Consumers Who Have Selected a Marketplace Plan."

(d) Persons Who Received Advanced Premium Tax Credit, 2018. As above, these figures are available at Kaiser Family Foundation, *Marketplace Plan Selections with Financial Assistance*, https://www.kff.org/health-reform/state-indicator/marketplace-plan-selections-by-financial-assistance-status-2/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited June 5, 2018). In particular, see the column, "Consumers Receiving Advanced Premium Tax Credits (APTC)."

(e) State Expanded Medicaid, as of 2018. These figures and related information, as of May 31, 2018, are available at Kaiser Family Foundation, *Status of State Action on the Medicaid Expansion Decision*, https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited June 5, 2018).

(f) Changes in Medicaid Enrollees, 2013-March 2018. These figures are based on data, as of May 31, 2018, available at Kaiser Family Foundation, *Total Monthly Medicaid and CHIP Enrollment*, https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=2&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited June 5, 2018). In particular, these figures represent the difference between the March 2018 numbers in "Total Monthly Medicaid/CHIP Enrollment" and the corresponding numbers in "Pre-ACA Average Monthly Enrollment."

(g) Gains in Young Adults' Insurance Coverage, 2013. These figures are available at Office of the Assistant Secretary for Planning and Evaluation, *Compilation of State Data on the Affordable Care Act*, U.S. Department of Health & Human Services, https://aspe.hhs.gov/compilation-state-data-

affordable-care-act (last visited June 7, 2018). In particular, see the column, "Individuals who Gained Coverage by Staying on their Parents' Plan Until Age 26."

EXHIBIT 2

EXHIBIT 2

Chart of Other Selected Measures of Improved ACA Public Health Services in the Nation and Plaintiff States[3]

State	Individuals with Pre-Existing Condition Protected by Insurance Reforms, 2009 (a)	Medicare Enrollees Receiving Free Preventive Services, 2016 (b)	Medicare Enrollees Gaining from Elimination of Prescription Drug Donut Hole, 2016 (c)	Increase in Community Health Center Patients, 2010-16 (d)	Grants from Prevention & Public Health Fund, FY 2012-17 (e)
	# persons	# persons	# persons	# persons	dollars $
United States	***133,936,025***	***40,125,350***	***4,918,043***	***6,384,240***	***$3,361,599,339***
20 Plaintiff States	***49,932,636***	***15,474,545***	***1,836,852***	***1,949,912***	***$1,065,371,113***
Alabama	2,040,458	723,236	83,177	37,021	$43,645,681
Arizona	2,794,358	811,881	94,103	164,200	$56,005,708
Arkansas	1,239,180	425,633	37,972	44,728	$26,252,181
Florida	7,838,642	3,105,961	344,343	357,502	$92,747,621
Georgia	4,323,897	1,131,729	138,291	145,605	$114,321,854
Indiana	2,796,375	852,064	121,432	214,370	$41,300,951
Kansas	1,213,671	350,868	43,280	60,078	$44,144,456
Louisiana	1,951,886	573,124	67,992	177,933	$47,414,483
Maine	590,266	219,457	18,792	10,859	$33,004,304
Mississippi	1,261,721	411,898	38,902	-19,560	$33,629,710
Missouri	2,601,893	821,438	102,643	134,269	$52,301,248
Nebraska	767,878	222,732	29,089	21,523	$38,540,972
North Dakota	275,556	85,737	11,110	9,534	$17,264,503
South Carolina	1,991,315	732,953	95,493	62,122	$57,797,485
South Dakota	345,932	110,661	12,563	8,088	$17,495,736
Tennessee	2,764,651	934,536	108,136	21,183	$56,319,873
Texas	10,694,840	2,639,862	333,523	360,335	$143,033,950
Utah	1,150,918	230,709	27,331	36,373	$47,547,220
West Virginia	799,920	294,459	42,416	66,407	$30,035,390
Wisconsin	2,489,279	795,607	86,264	37,342	$72,567,787

[3] Sources for these statistics are identified on the following page and correspond to the parenthetical letter in each column heading. For example, for the sources of statistics in the column "Individuals with Pre-Existing Condition Protected by Insurance Reforms, 2009 (a)," see the text at "(a)" on the following page.

(a) Individuals with Pre-Existing Condition Protected by Insurance Reforms, 2009. These figures are available at Centers of Medicare and Medicaid Services, *The Center for Consumer Information & Insurance Oversight*, https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/#Patient%E2%80%99s%20Bill%20of%20Rights (last visited June 5, 2018). In particular, see the link, "Data Files – First and Second Estimates by State," which opens a spreadsheet containing the column, "Total non-elderly with pre-ex: Second Estimate."

(b) Medicare Enrollees Receiving Free Preventive Services, 2016. These figures are available at Centers of Medicare and Medicaid Services, *Beneficiaries Utilizing Free Preventive Services by State, 2016*, https://downloads.cms.gov/files/Beneficiaries%20Utilizing%20Free%20Preventive%20Services%20by%20State%20YTD%202016.pdf (last visited June 5, 2018). In particular, see the column, "Medicare Total All Free Services."

(c) Medicare Enrollees Gaining from Elimination of Prescription Drug Donut Hole, 2016. These figures are available at Centers of Medicare and Medicaid Services, *State-by-State Information on Discounts in the Medicare Part D Donut Hole through December 2016*, https://downloads.cms.gov/files/Part%20D%20Donut%20Hole%20Savings%20by%20State%20YTD%202016.pdf (last visited June 5, 2018). In particular, see the column, "Total No. of Beneficiaries."

(d) Increase in Community Health Center Patients, 2010-16. These figures are available at Peter Shin et al., *Changes in Health Center Patients Served, 2010-2016*, Milken Institute School of Public Health & RCHN Community Health Foundation, June 2018, https://publichealth.gwu.edu/sites/default/files/downloads/HPM/GGHealthCenterDataInsights_June%202018.pdf.

(e) Grants from Prevention & Public Health Fund, FY 2012-17. These figures are based on data available at Trust For America's Health, *Updated Prevention and Public Health Fund (PPHF) State Funding Data (FY10-FY17)* (last updated Mar. 27, 2018), http://healthyamericans.org/health-issues/news/updated-prevention-and-public-health-fund-pphf-state-funding-data-fy10-fy17/. In particular, these figures represent the sums of the totals in the CDC spreadsheet and the Other Federal Agencies spreadsheet for fiscal years 2012 through 2017.

EXHIBIT 3

EXHIBIT 3

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